

Margaret L. Winter life insurance

**S. Robert
Powell <srp18407@gmail.com>**

2:00 PM, 01-26-
2015

to hrdirect@akzonobel.com, [877-259-6560]

01-26-2015

Dear Akzo Nobel:

Just spoke with a very helpful person at Akzo about the life insurance benefit of a former Akzo employee, Margaret Louise Winter, who died on September 30, 2014.

Attached is a copy of the Death Certificate of Margaret Louise Winter.

Attached, also, is a copy of the Short Certificate from the County of Lackawanna, State of Pennsylvania, naming me as the executor of the estate of Margaret Louise Winter.

Your assistance in this matter is much appreciated.

Sincerely,

S. Robert Powell
Post Office Box 151
Carbondale, PA 18407-0151

[570-282-0385](tel:570-282-0385)

2 Attachments

Preview attachment MLW death certificate.jpg



MLW death certificate.jpg

Preview attachment MLW short certificate.jpg



MLW short certificate.jpg

Received 2:24 P.M. on 01-26-2015



AKZONOBEL HRDIRECT

2:19 PM, 01-26-
2015

to me

Thank you for the documentation Robert,

I have added this to the existing case for Margaret, once they review this information they will be reaching out to you, please allow a few days since this takes a while.

Sincere regards,

Shanna Landberg

HR Customer Service Representative
AkzoNobel HR Shared Service Center

www.anhrinfo.com

T +1 877 259 6560

F +1 312 544 7014

E hrdirect@akzonobel.com

AkzoNobel, Inc.

525 W. Van Buren St.
Chicago, IL 60607

www.akzonobel.com

Follow AkzoNobel online at www.akzonobel.com/followus

4:19 P.M., January 30, 2015

Lynette, from AkzoNobel just phoned to report that they were moving forward with the processing of the Margaret Winter life insurance benefit processing. "In 1999, Margaret Winter named you as the primary beneficiary. Let me confirm your Social Security number and mailing address. [We did so.] You will be hearing from Minnesota Life in seven to ten days with details on the payment of this life insurance benefit. If you have any questions, you can reach me at 877-259-6560."

Minnesota Life Insurance Company
A Securian Company

Group Division Claims
P.O. Box 64114
St. Paul, MN 55164-0114
For claims information:
1-888-658-0193
651-665-7106 fax
www.minnesotalife.com/benefits

MINNESOTA LIFE

February 2, 2015

S Robert Powell
PO Box #40
Carbondale, PA 18407

RE: POLICY # 34164 – AkzoNobel, Inc
CLAIM # 1100168
INSURED: Margaret Winter

Dear Mr. Powell:

We received notice of a claim for life insurance benefits as a result of the passing of Margaret Winter. Please accept our company's condolences on your loss.

You are a beneficiary of life insurance benefits under the policy number listed above. The next steps in the claim process are for you to complete and return the following forms to us (a return envelope is enclosed):

- **Beneficiary Statement** for your personal information and to claim the insurance
- **Certified copy of the death certificate** (this must be an original with the cause and manner of death – no photocopies please)

We appreciate your cooperation during this difficult time and are here to assist you. If you have any questions during the processing of your claim, please contact us at the toll free number listed above and a customer service representative will assist you. You may also check the status of your claim by visiting www.securian.com/benefits.

Sincerely,



Brenda Fahrenbrink
Claims Examiner
Group Claims

Frequently Asked Questions

Questions about the claim process:

How can information be submitted to your office?

Certified Documents (e.g. death certificate, letters of administration, and letters of guardianship) must be original. Please mail certified documents to:

For Standard Mail:

Minnesota Life Insurance
Attn: Group claims
PO Box 64114
St. Paul, MN 55164-0114

For Certified/Overnight Mail:

Minnesota Life Insurance
Attn: Group Claims
400 Robert Street North
St. Paul, MN 55101-2098

All other information may be mailed, faxed to 651.665.7106, or submitted through our secure website at www.securian.com/benefits. To submit information through the website, select "Contact us" and then select the "E-mail" button next to "Employer (current or previous)."

Documents submitted by fax or through our website are typically added to your claim within 24 hours.

How long does the review process take after I've submitted the requested information?

Once we have received all the requested information, our review process takes approximately 7-10 days to make a determination. In circumstances where additional review is needed, the claim review time may be extended. If additional information is needed from you, your examiner will contact you.

What is the best way to contact you or check the status of my claim?

To see if your claim has been paid, you may go to www.securian.com/benefits, and click "View existing claim information." You may also email us by using the "Contact us" option on the web site and then selecting the "E-mail" button next to "Employer (current or previous)" and we will typically respond within 24 hours. Our toll free number 1-888-658-0193 is an additional option if you prefer to call us.

Questions about the claim form:

Why do you need my social security number (SSN)?

We use the personal information of the beneficiary to verify his or her identity. We also obtain your SSN as it is required by the IRS for reporting purposes.

Should I cross out item number 2 in the "CERTIFICATION" section?

You should **not** cross out item number 2 unless you have been directly notified by the IRS that you are subject to backup withholding.

Should I provide a Foreign Account Tax Compliance Act (FATCA) code under item 4 in the "CERTIFICATION" section?

You should **not** provide a FATCA code, unless you are requesting we send the funds outside of the United States, AND you are exempt from reporting under the Foreign Account Tax Compliance Act. Further information about FATCA can be found on the IRS website.

We hope this information is of assistance to you. If you would like additional information and resources on end-of-life issues, please visit www.LegacyPlanningServices.com.

Mailed by SRP, 02-07-2015

Beneficiary Statement

Minnesota Life Insurance Company - A Securian Company
Claims • P.O. Box 64114 • St. Paul, MN 55164-0114

For claim information call:
Toll free 1-888-658-0193
Fax 651-665-7106

MINNESOTA LIFE

PART 1 - All fields must be completed in Part 1 including your signature

Name of deceased (last, first, middle initial) <u>WINTER, MARGARET L.</u>	Policy number <u>34164</u>	CLAIM NUMBER <u>1100168</u>
Date of birth (mo/day/yr) <u>08-01-1940</u>	Date of death (mo/day/yr) <u>09-30-2014</u>	
Name of beneficiary (last, first, middle initial) <u>POWELL, S. ROBERT</u>		

CERTIFICATION INSTRUCTIONS: You must cross out item (2) below if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest or dividends on your tax return. However, if after being notified by the IRS that you were subject to backup withholding you received another notification from the IRS that you are no longer subject to backup withholding, do not cross out item (2).

CERTIFICATION - Under penalties of perjury, I certify that:

- (1) The number shown on this form is my correct Social Security number or Taxpayer Identification number, **and**
 - (2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding, **and**
 - (3) I am a U. S. person (including a U. S. resident alien), **and**
 - (4) The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.
- Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____

Certification Notice:

THE IRS REQUIRES US TO OBTAIN CERTIFICATION OF YOUR SOCIAL SECURITY NUMBER OR TAXPAYER IDENTIFICATION NUMBER. WITHOUT THIS INFORMATION, YOU MAY BE SUBJECT TO GOVERNMENT IMPOSED BACKUP WITHHOLDING FOR ANY INTEREST PAID ON THE DEATH BENEFIT.

Relationship to deceased <u>COUSIN</u>	Beneficiary's date of birth <u>12-12-1943</u>
Signature of beneficiary <u>X S. Robert Powell</u>	Date signed <u>02-07-2015</u>
Address of beneficiary (street, city, state, zip) <u>R.R. 1, Box 40, CARBONDALE, PA 18407</u>	Beneficiary's Social Security number <u>198-34-0586</u>
	Beneficiary's telephone number <u>570-282-0385</u>

PART 2 - PAYMENT INFORMATION (Benefits will be sent to you via a check if Part 2 is not fully completed and signed.)
How would you like to receive the proceeds payable to you?

☒ Check ☐ Direct Deposit - if you select this option, you must complete and sign the bottom of this form.

Authorization for Direct Deposit

I authorize Minnesota Life Insurance Company ("Company") to initiate deposits (credit entries) and corrections (debit entries) to adjust any deposits made in error to my account indicated below. I authorize the financial institution ("Depository") named below to accept these deposits and/or corrections made to this account.

This authorization is to remain in full force and effect until Company has received written notification from me of its termination in such time and manner as to afford Company and Depository a reasonable opportunity to act on it or until such time as Company terminates this method of payment.

Name of depository (bank, credit union, etc.)		Depository telephone number	
Street	City	State	Zip code
Account type ☐ Savings ☐ Checking	Bank routing/transit number	Account number	

IMPORTANT: For purposes of accuracy, PLEASE ATTACH A VOIDED CHECK OR SAVINGS DEPOSIT SLIP.

Signature of beneficiary <u>X</u>	Date signed
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PART 3 - NOTICE

For your protection, state laws require the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

LOCAL REGISTRAR'S CERTIFICATION OF DEATH

WARNING: It is illegal to duplicate this copy by photostat or photograph.

Fee for this certificate, \$6.00

P 20965222

Certification Number



This is to certify that the information here given is correctly copied from an original Certificate of Death duly filed with me as Local Registrar. The original certificate will be forwarded to the State Vital Records Office for permanent filing.

Flayd R. Evans
Local Registrar

10/02/2014
Date Issued

Type/Print In
Permanent
Black Ink

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF HEALTH • VITAL RECORDS

CERTIFICATE OF DEATH

1. Decedent's Legal Name (First, Middle, Last, Suffix) Margaret Louise Winter		2. Sex female		3. Social Security Number 161 34 6622		4. Date of Death (Mo/Day/Yr) (Spell Mo) Sept 30 2014	
5a. Age-Last Birthday (Yrs) 74		5b. Under 1 Year Months 0 Days 0 Hours 0 Minutes 0		6. Date of Birth (Mo/Day/Year) (Spell Month) Aug 1 1940		7a. Birthplace (City and State, or Foreign Country) Carbondale Pa	
8a. Residence (State or Foreign Country) Penna		8b. Residence (Street and Number - Include Apt No.) 337 McKinley Ave		8c. Did Decedent Live in a Township? ☐ Yes, decedent lived in _____ twp. ☒ No, decedent lived within limits of _____ city/boro.		7b. Birthplace (County) Lackawanna	
8d. Residence (County) Lackawanna		8e. Residence (Zip Code) 18433		9. Ever in US Armed Forces? ☐ Yes ☒ No ☐ Unknown		10. Marital Status at Time of Death ☐ Divorced ☒ Never Married ☐ Married ☐ Widowed	
11. Surviving Spouse's Name (If wife, give name prior to first marriage)		12. Father's Name (First, Middle, Last, Suffix) Albert Winter		13. Mother's Name Prior to First Marriage (First, Middle, Last) Margaret Louise Russell		14. Informant's Name (If not institution, give street and number) Robert Powell	
14a. Informant's Name (If not institution, give street and number) Robert Powell		14b. Relationship to Decedent cousin		14c. Informant's Mailing Address (Street and Number, City, State, Zip Code) P.O. Box 151 Carbondale Pa 18407		15a. Place of Death (Check only one) ☐ If Death Occurred Somewhere Other Than a Hospital ☒ Emergency Room/Outpatient ☐ Dead on Arrival ☐ Nursing Home/Long-Term Care Facility ☐ Hospice Facility ☐ Decedent's Home	
15b. City or Town, State, and Zip Code Scranton Pa 18510		15c. Date of Disposition Oct 2 2014		15d. County of Death Lackawanna		16. Method of Disposition ☐ Burial ☒ Removal from State ☐ Donation ☐ Other (Specify) _____	
16a. Location of Disposition (City or Town, State, and Zip) Archbald Pa 18403		16b. Date of Disposition Oct 2 2014		16c. Place of Disposition (Name of cemetery, crematory, or other place) Maple Hill Crematory		17a. Signature of Funeral Service Licenses or Person in Charge of Interment <i>Charles A. Battenberg</i>	
17b. License Number 009803		17c. Name and Complete Address of Funeral Facility Charles A Battenberg FH 363 Washington Ave Jermyn Pa. 18433		18. Decedent's Education - Check the box that best describes the highest degree or level of school completed at the time of death. ☐ 8th grade or less ☐ No diploma, 9th - 12th grade ☐ High school graduate or GED completed ☐ Some college credit, but no degree ☐ Associate degree (e.g. AA, AS) ☐ Bachelor's degree (e.g. BA, AB, BS) ☒ Master's degree (e.g. MA, MS, MEd, MEd, MSW, MBA) ☐ Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)		19. Decedent of Hispanic Origin - Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino. ☒ No, not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latino (Specify) _____	
20. Decedent's Race - Check ONE OR MORE races to indicate what the decedent considered himself or herself to be. ☒ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other (Specify) _____		21. Decedent's Single Race Self-Designation - Check ONLY ONE to indicate what the decedent considered himself or herself to be. ☒ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other (Specify) _____		22a. Decedent's Usual Occupation - Indicate type of work done during most of working life. DO NOT USE RETIRED. manager		22b. Kind of Business/Industry Salt	
23a. Date Pronounced Dead (Mo/Day/Yr) September 30 2014		23b. Signature of Person Pronouncing Death (Only when applicable) <i>Claire Festa RN</i>		23c. License Number RN281456L		24. Time of Death 4:30 - 2014	
24. Time of Death 4:30 - 2014		24. Time of Death 4:30 - 2014		24. Time of Death 4:30 - 2014		24. Time of Death 4:30 - 2014	
25. Was Medical Examiner or Coroner Contacted? ☐ Yes ☒ No							
26. Part I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. End stage Respiratory Due to (or as a consequence of): b. COPD (Chronic Obstructive Pulmonary Disease) Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Due to (or as a consequence of):							
26. Part II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
27. Was an autopsy performed? ☐ Yes ☒ No							
28. Were autopsy findings available to complete the cause of death? ☐ Yes ☒ No							
29. If Female: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year							
30. Did Tobacco Use Contribute to Death? ☒ Yes ☐ Probably ☐ No ☐ Unknown							
31. Manner of Death ☒ Natural ☐ Homicide ☐ Accident ☐ Pending investigation ☐ Suicide ☐ Could not be determined							
32. Date of Injury (Mo/Day/Yr) (Spell Month)							
33. Time of injury							
34. Place of Injury (e.g. home; construction site; farm; school)							
35. Location of Injury (Street and Number, City, County, State, Zip Code)							
36. Injury at Work ☐ Yes ☒ No							
37. If Transportation Injury, Specify: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify) _____							
38. Describe How Injury Occurred:							
39a. Certifier - physician, certified nurse practitioner, medical examiner/coroner (Check only one). ☒ Certifying only - To the best of my knowledge, death occurred due to the cause(s) and manner stated. ☐ Pronouncing & Certifying - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. Signature of certifier: <i>Thomas E. Magerman</i> Title of certifier: <i>MD</i> License Number: <i>21204924L</i>							
39b. Name, Address and Zip Code of Person Completing Cause of Death (Item 29) <i>Thomas E. Magerman MD 221 River St Scranton Pa 18447</i>							
40. Registrar's District Number 35-312							
41. Registrar's Signature <i>Flayd R. Evans</i>							
42. Registrar File Date (Mo/Day/Yr) October 2, 2014							
43. Amendments							

Disposition Permit No. **1068005**